Kentucky Behavioral Health Planning and Advisory Council
Council Meeting Summary
November 16, 2017 10:00am to 2:00pm
Kentucky Transportation Cabinet, 200 Mero Street, Frankfort, Kentucky

Council Members: Gayla Lockhart, Lynn Haney, Melony Cunningham, Steve Lyons, Mike Barry, Jeanette Rheeder, Peggy Roark, LeeAnn Kelley, Sherry Sexton, Steve Shannon, Carmilla Ratliff, Ron O'Hair, Bill Heffron, Becky Clark, Maggie Krueger, Shelley Elswick, Joy Hoskins, Franci Middleton, Kyle Burchett, Linda Lucas, Kalon Bagby
Staff: Michele Blevins, Melissa Runyon, Christie Penn, Jane Oliver, Koleen Slusher, Rita Ruggles, Allison Paul, Michelle Kilgore, Beth Jordan
Guests: Lisa Burchett, Mary Singleton
Presenter: Kris Shera

Topic	Discussion	Next Steps
Call Meeting to Order	Gayla Lockhart, Chair, called the meeting to order at 10:04 AM and welcomed members and guests. Quorum was confirmed. Members, guests and staff introduced themselves.	
Approval of August 2017 Meeting Summary	Members reviewed the August 2017 meeting summary. Mike Barry made a motion to approve the minutes as written. Sherry Sexton seconded. **Motion passed.**	Approved meeting summaries are available online at http://dbhdid.ky.gov/dbh/kbhpac.aspx.
Committee Reports	Executive Committee – will meet on Thursday, January 25, 2018. Membership Committee Gayla Lockhart, Chair, provided a report to the Council. The Membership Committee will hold a meeting on January 25th to review membership applications. A membership application and a list indicating members' term expiration dates were included in the handouts. Staff read aloud the names of members whose terms expire March 2018. Gayla encouraged members to share applications with interested individuals and to note that the Council has particular need of parents of children with behavioral health challenges and increased diversity. The Member Orientation will be April 18, 2018. Finance and Data Committee – will meet on Thursday, April 19, 2018 Bylaws Committee – will meet on June 14, 2018. A copy of the Bylaws was included in the handouts. Members are asked to review and send recommendations to staff. Advocacy and Policy Committee Mike Barry, Chair, reported that a teleconference will be scheduled soon to review the Council's Legislative Priorities.	The membership application is available online: http://dbhdid.ky.gov/dbh/documents/kbhpac/MemberApp.pdf.

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2018 Behavioral Health Report	Michele Blevins discussed the Behavioral Health Report due December 1, 2017. Hard copies of the report were made available to members. Numbers of individuals served by CMHCs decreased slightly for some populations. Discussed possible reasons for this such as the open network allows for additional providers and not everyone sees CMHC, more children and families are seeing private providers, CMHC services are focusing more on quality and less on quantity, etc. Discussion about focusing on adult and youth peer specialists but not as much focus on family peer support specialists. Gayla Lockhart read the letter to Virginia Simmons regarding Council support of the Behavioral Health Report that will be submitted with the report. Gayla signed the letter as chair of the Council.	Behavioral Health Report to be submitted December 1, 2017.
CSAT Site Visit Report	• Michele Blevins provided an update on the drafted Center for Substance Abuse Treatment Compliance Report received in February 2017, from the site review conducted September 14-18, 2015. A finalized report has not been received by DBHDID to date. Copies of the draft report are available upon request . In the report, the following were listed as assets: • The current Commissioner's commitment to behavioral health. • The physical location of DBHDID in relationship to partner agencies, Public Health, Medicaid Services, Community Based Services. In the report, the following were listed as areas needing further development: • The cultural and ethnic composition of DBHDID staff does not mirror that of the 418,540 clients served by the agency in 2015. The lack of diversity in staff could result in clients not receiving services that are culturally and linguistically appropriate. Recommendations: • A formalized cultural competency plan and training mechanism that is grounded in the National Culturally and Linguistically Appropriate Services (CLAS) Standards. • The Compliance Team recommends Kentucky formalize and document the needs assessment processes/methodology the Regional Prevention Centers use to ensure that Kentucky has an accurate representation of the met and unmet needs and populations in need of treatment. The same process and methodology should also be reflected in upcoming SABG applications. The methodology should be consistent from year to year.	

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Kentucky Care Integration Grant	Kristopher Shera provided an overview of a new five-year, $10 million federal grant awarded to the Cabinet for Health and Family Services to promote the integration of primary care and behavioral health in two regions of the Commonwealth, Kentucky Care Integration (KCI). Kentucky was one of three states chosen by the Substance Abuse and Mental Health Services Administration (SAMHSA) to receive the Promoting Integration of Primary Behavioral Health Care (PIPBHC) grant. DBHDID will implement KCI with two service region providers - Centerstone of Kentucky and Mountain Comprehensive Care Center. These two CMHCs will integrate services by developing collaborative relationships with federally qualified health centers, Family Health Centers, HomePlace Clinics, and a variety of other community stakeholders and partners. Implementation of KCI began with the formation of local implementation teams and advisory councils. Integrated primary care and behavioral health services will begin prior to January 1, 2018.	
Environmental Factor - Person Centered Recovery Planning	Person Centered Recovery Planning (PCRP) is a process through which individuals develop their own plan of service. This process may include a representative the person has freely chosen (natural supporters), family members, friends, caregivers, and others whom the individual wishes to include. PCRP identifies the person's strengths, goals, preferences, needs and desired outcomes. Missy Runyon reviewed the work that has been done by state and regional staff during the past three years to increase PCRP. Planning Council members were asked for feedback and the following information was submitted (Responses have been edited for brevity): **1. Describe some ways that individuals receiving services can be more included in the process of deciding their own desired outcomes and planning their own treatment.** *Individuals should be provided with a Peer Supporter and natural supporters to help empower them to advocate and speak up for themselves. Their individual voices matter and team members need to listen to the individual's own desires, regardless of age.* *Survey the individual as to best learning style. Utilize this to convey plans of treatment.* *By giving the individuals the freedom to choose. Helping to build confidence and self-efficacy in individuals. Giving them time and attention that they need to build skills. No treating them like a number. Helping them with baby steps to accomplish and then move on to bigger tasks.* *Individuals in recovery first need to be educated that they have the option to choose. I think a lot of times the consumer does not even*	

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	know that. I work in a state psychiatric hospital as a peer support specialist. Sometimes in groups we go around the room and ask the patients what they want for their futures when they are released. You can tell that some of them have been in the revolving door for so long, they might have no other dreams for their lives. They might have lost all hope. They also might have never been asked that question. Just having the discussion about their future, hopes and dreams can sometimes get the wheels turning in order to think that there might indeed be more for their lives. Having examples ready of others who have done such things for their lives is important, such as a peer specialist they can look to for hope in saying, if they can do this, so can I! Helping provide them with steps in a plan of action is important too. They might know what they want, but not know how to work the system or how to make their dreams a reality. **2. Describe some ways that legal guardians can become more involved in the process of assisting individuals with planning their own treatment.** *Family-driven, youth-guided philosophy needed for youth peer supporters need to be involved to help legal guardians involved.* *Family mediation (Court of Justice has a roster of mediators, some who specialize in elder care) which is much less than an attorney. The planning can be successfully completed with everyone being happy with outcome, utilizing knowledgeable mediator.* *Questions. Tests. Check their records of interest of past school. There might be a quality or a desire overlooked. Thank you.* *First the caregiver needs to be educated that the person living with the mental illness can recover and both the caregiver and the individual need to learn that confidence step by step. Then taking the time in working together to make that happen.* *They need more information/education as to the steps for planning, so as to maintain focus. Encouraging "baby steps" and completing/managing treatment target points (Carolyn Wheeler – Great resource).* **3. Describe some ways that natural supporters, such as family members, caregivers, friends, etc., can become more involved in the process of assisting their loved ones with planning their own treatment.**	

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	Natural supporters need to be included and invited to planning treatment as long as natural supporters are positive. Peer support workers can also help engage the client and natural supporters *Utilization of support groups for family members to educate them to what the loved one has and will go through in the recovery process.* *Education is key. The more the outside circle has understanding of the problem(s), the greater a support chain can/will be established to "cheer" on and reinforce loved one's courageous positive steps.* *I couldn't have done it on my own and then there is me all of my ideas about life, dreams were turned over and today I still seek perfection instead of progress and struggle staying in the present and staying out of tomorrow. When I can see and agree then I am out of the way. Thank you.* *It is important for caregivers, and family members to have confidence in their loved ones. A way to build confidence in the caregiver, is to share examples of other consumers who have gone far in their personal recovery. Share stories of how that has been accomplished. In example, taking meds, making appointments, example of self-care, positive coping skills that have been beneficial to others who have walked the same path. Caregivers need support in this process as well. They are scared for their loved ones, and could be over protective. It needs to be educated how empowering it is for an individual to follow their own dreams and have the autonomy to do so. To explain how beneficial this can be for the person. A person will always be more successful if they are chasing their dreams or allowed to do so as opposed to following others' will that is imposed upon them. The caregivers need to be educated on options in the community and how to navigate the system for their loved ones. They need to be educated on the importance of support and personal confidence that the consumer needs to possess and how to help build that esteem in their loved ones.* *Helping them to overcome the fear in letting their family member go. We all make mistakes in life and we all need to learn how to pick ourselves up and dust off and keep going. An individual with mental illness will not learn those skills and the confidence and decision making that comes along with them unless they learn by experience. Again this takes patience and time and this is what a lot of family members lose after their loved one has been sick for so long.* **4. Please list some of the barriers in the behavioral health system to any of the above questions.**	

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	The push for person centeredness needs to continue. Providers in the system need to be educated on the recovery movement and that individuals indeed do recover. The system needs to find ways and time to work with individuals to provide options and educate consumers on the consequences of their actions. I think much work needs to be done on encouragement and self-esteem building. I think providers need to ask the consumers themselves, what would you like for your life? What are some goals you would like to obtain and how can we get you there? I think language needs to be shared from the provider to the consumer telling them that they still can live happy productive lives after diagnosis. This approach needs to be taken as opposed to milling patients in and out, providing medicine after 15 minutes, and sending them on their way. Open patients' eyes to different ways of life. Have these discussions in hopes that the patients will find something they want to do in their life that is meaningful and chase after that dream! *The perception that pharmaceuticals are the only solution. No one is acknowledging the greatest connection to infancy/childhood trauma. Please note Dr. Gabor Mate's research and literature.* *Doctors do not have enough time to spend with patients. They are overworked and underpaid. Trying to meet insurance regulations, the personal time and attention a patient needs to build these skills from another individual is the first thing that is lost and it is what is needed the most. WE need to understand as a society what mental illness is and that people can recover. Our system is broken. From the ground up time needs to be put into these individuals to help them build the confidence that they so need in order to make decisions for themselves. Individuals do know what is best for themselves. WE have to believe in the patients, give them the time and connection that they need. It doesn't happen overnight and everyone wants a quick fix. We have to slow down and give them what they need.*	
Department Updates	Staff shared the following department news: • Council staff, Missy Runyon, is retiring November 30th; • DUI Director, LeeEtta Cummings, is retiring December 31st. • Policy Analyst for the Substance Use Prevention and Treatment Block Grant Policy Analyst, Sara Barker, retired, September 30th; • The department received the latest Amended Settlement Agreement report from the Independent Reviewer, Diane Brewer. The report noted many accomplishments. There has been conversations of the agreement being continued. • The department is hosting a two-day Structured Clinical Interview for DSM Disorders training next week.	

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Member Updates	Members shared updates and information about important upcoming events in round robin format. Some of the highlights included: • Melony Cunningham reported that NAMI Kentucky's 2018 Annual Conference is September 22nd in Lexington. NAMI KY is working on a collaboration with DCBS, fundraising opportunities, and preparing for increased funding for Ending the Silence trainings. • Carmilla Ratliff shared that Kentucky Partnership for Families and Children (KPFC) has formed a committee to strengthen its satellite offices. KPFC and TAYLRD staff were trained in Youth Thrive, a two-day training that focuses on promoting 5 protective factors for youth, and will have follow-up training in Florida. • LeeAnn Kelley shared that KPFC will be hosting a Parent Café Facilitator Training on November 30th. KPFC is also teaming with WellCare looking for young adults age 17-23 with lived experience in foster care. • Ron O'Hair reported that OVR will soon be offering Disability Benefits 101, a website that tells how employment will impact benefits. • Mike Barry of People Advocating Recovery (PAR) stated that the organization hosted its 1st Annual Recovery Dinner at the UK Alumni Club and plans to host it again next year. Mike shared that approximately 1,500 people attended the annual Sober Walk & Rally on September 9th. PAR's year-long Leadership Academy is underway with a new class of participants. PAR has formed a new Addiction Policy and Advocacy Council that is focused on legislative advocacy. PAR is providing education and distribution of Narcan kits to community organizations in Eastern Kentucky. • Dr. Heffron reported that DJJ has finished piloting Aggression Replacement Training, a cognitive behavioral therapy for high-risk adolescents in the justice system. DJJ will expand the treatment modality to more detention centers in the spring. Staff are also looking at ways to reduce recidivism and cognitive behavioral treatment modalities for adolescents in group homes. • Kalon Bagby shared that the Department for Community Based Services (DCBS) will soon have a hotline that individuals may call to determine if they meet criteria to receive kinship care funds. Kalon also shared that this will be her last meeting as she has taken a new position. Council members and staff wished Kalon well and thanked her for her years of service to the Council. • Shelley Elswick shared that Voices of Hope - Lexington has launched telephone recovery support.	To learn more about annual conference: http://namikyadvocacy.com/Events.aspx For more information and to register for KPFC trainings: https://kypartnership.org/category/news/ For more information about PAR events: http://www.peopleadvocatingrecovery.org/index.htm

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	• Joy Hoskins shared that the Department for Public Health (DPH) now has 38 Harm Reduction Syringe Programs in 33 counties and that all health departments now have Narcan stored on their crash carts as a protocol. DPH is working with the KY Pharmacy Association's mobile pharmacy to distribute Narcan.	
Adjournment	LeeAnn Kelley made a motion to adjourn the meeting at 2:05 pm. Maggie Krueger seconded. **Motion passed.**	Next Meeting: Thurs, March 15, 2018 10:00 a.m. – 2:00 p.m. KY Transportation Cabinet, Room 107